DOCUMENT RESUME

ED 070 220 EC 050 242

AUTHOR	Ora, John P.; And Others
TITLE	Instruction Pamphlet for Parents of Oppositional Children.
INSTITUTION	George Peabody Coll. for Teachers, Nashville, Tenn.; Tennessee State Dept. of Mental Health, Nashville.
SPONS AGENCY	Bureau of Education for the Handicapped (DHEW/OE), Washington, D.C.
PUB DATE	Jan 71
GRANT	OEG-0-9-520320-4535(618)
NOTE	49p.
EDRS PRICE	MF-$0.65 HC-$3.29
DESCRIPTORS	*Behavior Change; *Behavior Problems; Behavior Theories; Emotionally Disturbed; *Exceptional Child Services; Guidelines; *Parent Education; Parent Role; *Positive Reinforcement; Preschool Children

ABSTRACT

The pamphlet contains explanations and instructions for parents of oppositional preschool children (negative, destructive, or uncooperative children) who are enrolled in a Regional Intervention Project (RIP) behavior modification program. Explained in basic terms are the behavior theories related to why a child becomes oppositional and how to change his behavior through the technique of differential reinforcement. Parents are taught to attend only to desirable behavior of the child (positive reinforcement) and to ignore undesirable behavior (withdrawal of positive reinforcement). Special instructions are given for handling dangerous or very destructive behavior which cannot be totally ignored. The pamphlet also contains instructions to technicians (other previously trained parents) for guiding the new parents through the periods of baseline, intervention, reversal, return to intervention, and eventual fading of positive reinforcement to an intermittent schedule of reinforcement. (KW)

BEH EC

ED 070220

FILMED FROM BEST AVAILABLE COPY

Instruction Pamphlet for Parents of Oppositional Children

John P. Ora

and

The RIP Oppositional Child Technicians

Regional Intervention Project for Preschoolers and Parents
Grant No. OEG-0-9-520320-4535 (618)
Handicapped Children's Early Education Assistance Act
Bureau of Education for the Handicapped

George Peabody College

1/1/71

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

EC 050 242

The Project presented or reported herein was performed pursuant to a Grant from the U.S. Office of Education, Department of Health, Education, and Welfare. However, the opinions expressed herein do not necessarily reflect the position or policy of the U.S. Office of Education, and no official endorsement by the U.S. Office of Education should be inferred.

Baseline Section (Distribute following sign-in)

Welcome. As a parent in the Regional Intervention Project you are about to assume your first responsibility - working with your own child. The situation you are in is referred to here as "oppositional child training." It is training based on work originally done at other universities. We have repeated, adapted, and extended the original research to meet a pressing demand for such a service from persons like yourself.

At this point you are probably feeling confused and frustrated, somewhat embarrassed at the prospect of having strangers observe your difficulties, and perhaps even hostile toward your child. These feelings are quite natural under the circumstances. Those of us who have been where you are now have felt the same way. No one can enjoy a child who in one way or another is constantly causing trouble. Rest assured that when we came our children could be variously described as "negativistic," "hyperactive," "whines," "cries a lot," "has temper tantrums," "hits," "bites," "is destructive." As one mother put it, "every event of his day is a confrontation." And indeed, this is what all the children in oppositional child training have in common. Despite being physically capable of cooperating, they have all apparently resisted what our culture views as reasonable requests. Hence the name "oppositional."

This packet will guide you through a training procedure that will resolve your difficulties with your child and leave you qualified to help, under professional supervision, others with similar problems. It will be given to you in sections as you progress. You will notice that at times the sections also contain instructions to the technicians. This practice is a convenient way not only of standardizing our technical procedures, but also of gradually introducing you to the technician's functions. Thus you will smoothly enter the final

phase of your own training -- training others. The manager or the module coordinator will provide guidance in assuming technician's duties.

Because of the ages of our children and the occupational roles of our culture, the mother is usually the principal person working with the child within the Project facilities. The father is equally important. Keep him well informed as to what is going on. He is welcome to observe and to participate in training if his job permits. Remember that he has agreed on intake that his minimum involvement will be to accept training from you, imitating you, following your instructions in dealing with the child, and seeking explanations from you for the changes in your behavior.

At this point you are probably very interested in knowing about how long this training will take. We can make a guess, but first a word of advice about what we mean by "this training." We refer to a technical change in parent-child behavior that will be fully explained to you in the next section, "Intervention." If you follow instructions, your child's "oppositional" behavior will not disappear (which might be undesirable), but it will decrease to well within normal limits. Because the stress produced by having an oppositional child can often have a "multiplier effect" on other problems, any other problems you have may appear to become less acute also. However, if you have money problems, "this training" will probably not help you. If your marriage is unhappy for reasons not related to the child's behavior, "this training" will not help you directly. In short, oppositional child training is not a cure-all. It is a technical intervention that will enable you to control your pre-schooler's behavior in ways that you will come to realize are extremely simple. With our "advice" in mind, if you work hard, come in as requested, and everybody stays healthy, we are reasonably sure that we can have most of your difficulties with your child resolved in a month. After that our emphasis will shift to consolidating

what you and your child have learned. You will continue play sessions at first weekly, then monthly.

As soon as baseline is over, every parent receives assignments to work in the Project. One of the first areas you will help in is the playschool. This is a rewarding and enriching experience, for here you will be able to put your newly learned techniques to work in a real situation, thus gaining valuable experience in dealing with children. Next, you will be trained to rate play sessions and to compute and graph data. This training as a technician will help you to consolidate what you have learned. Occasionally you will be called upon to show new clients around the Project. After intervention is completed and you are placed on follow-up, you will then receive a work assignment in perhaps another area. Thus, during the time that you and your child are being helped, you will be involved in the Project in ways that require constant review and application of what has been learned. In addition, you will have the satisfaction of helping others and using your access to expert advice to deal happily with the course of normal child development.

As for length of "baseline" itself as a part of "this training," a general explanation of what a baseline is may be of help. An essential first step in the behavioral sciences is to measure the behavior in question in order to determine what it is and what is to be changed. There are some rather difficult questions involved regarding the degree of change caused by the act of measurement and regarding the logic of relating the baseline to subsequent manipulations. None of these scientific matters need concern you at the moment. Only two points are important for you to grasp right now. First, a baseline, or the base rates of behavior, must be stable to provide a necessary subsequent comparison. Therefore, the number of baseline sessions cannot be specified in advance exactly. We can only say that we will intervene to help you when we have a

clear, stable picture of what is happening and that this rarely takes more than five or six sessions. Second, it cannot be emphasized too strongly that the baseline period of an applied behavioral analysis is the most important period. Assuming physical capability on the part of the child and control of certain other variables (which we have), then once an accurate baseline analysis is conducted, everything else follows quickly and simply. So during the next few sessions while you are coming in only to have the techs very carefully tell you nothing, remember, the only technically difficult aspect of training is occurring. Once your problem is identified, or, in most cases, confirmed, universal laws of behavior can probably be brought to bear to clear it up. To put the explanation another way, science can neither progress nor be successfully applied without proper measurement. Thanks to the previous research, in oppositional child training, as soon as we are sure of what to measure, we know exactly what to do.

Finally, we wish to emphasize an essential procedure. A complex, interdependent organization is being brought to bear to help you. Considerable scheduling is required. The manager arranges all schedules. She works out your appointment times with you. If you ever find that you have to miss an appointment, you must call her at once.

RIP Medical Regulations

The following regulations will be adhered to at all times in RIP because none of our children can afford to lose time in treatment through exposure to infection.

Parents are responsible for having their child's physician administer the immunizations listed under (1), if he has not already done so, and for having him list the child's immunizations and their dates on the Immunization Record sheet, to be returned with the blue Child Study Center medical form. Parents should also

complete the release of information section at the bottom of the immunization form so that RIP can coordinate closely with the physician.

Note that the diseases referred to in (2), (3), and (4) should be diagnosed by your child's physician, not by you. We all hesitate to bother a busy physician with trivia or "obvious" questions, but he understands that RIP children must be kept healthy and on program. Call him.

If you have any questions or problems, such as a sibling with a cold and no sitter, call the Project. You are not alone any more.

The following recommendations are made to promote cleanliness and reduce sources of infection in the RIP Project.

1. Immunizations

All RIP children should be immunized to or in the process of being immunized at the time of entering the Project. The following immunizations are recommended.

a. DPT--an initial series of 3 injections at 4-6 week intervals and a booster dose a year after the last injection.
b. Polio--oral polio vaccine, a series of 3 single-type doses or 2 trivalent doses with a trivalent booster a year after the last.
c. Measles vaccine.
d. Smallpox vaccination is recommended but is not an absolute requirement for the preschool child of this program. NOTE: A child with a skin rash should not be exposed to any child with a smallpox "take." This is particularly important in children with eczema or chronic allergic skin rash.

2. Contagious Diseases

Any RIP child with known contagious disease should not be brought to the center. The parent should notify the person in charge of the case or Mrs. Ray that the child is ill. Guidelines are listed for the commonly encountered contagious disease as to when the child may return to the Project.

a. German measles (or 3-day measles): 3-5 days after the onset of the rash.
b. Red measles: 5 days after appearance of rash.
c. Mumps: When swelling has subsided.
d. Chickenpox: After crusts have formed (not sooner than 7 days after onset of symptoms).

e. Strep throat: After 1 week of antibiotic treatment (such as penicillin).
f. Scarlet fever: After clinical recovery (7 days minimum), which usually includes 1 week of antibiotic treatment.
g. Impetigo: Should be treated by a physician and an attempt made to prevent contact with other children until the skin lesions are under control.

3. Upper Respiratory Infections

Children with severe upper respiratory diseases (colds, bronchitis, etc.) should be kept away from the remainder of children during the course of therapy sessions as much as possible. Because of the nature of this Project a child with mild runny nose or mild cough would not be excluded from sessions, but should stay away from well children as much as possible.

4. Playschool Area

Some brothers and sisters of RIP children stay in the playschool area during sessions. These youngsters should not be brought in if they have a contagious disease or a severe upper respiratory infection.

5. Illness at RIP

A child who becomes ill while at the center may be taken to the first aid room, number 113. There, the mother or a member of the staff should remain with the child until he can be transported home or to his physician.

6. Clean-Up Procedures

Following each therapy session, the mother should be responsible for cleaning up after her own child. Any spilled food should be cleaned up at the time the incident occurs with a damp cloth or paper towel. The bathroom and classroom facilities should be cleaned daily at the end of the workday.

Technicians

Your primary job during baseline is of course to provide mother with the support and reassurance that only you, as mothers of former "oppositional children," can provide. You do this by being yourself as you are now. Let her describe how bad her situation is if she wants to. Listen well and describe to her how you used to be only if it seems relevant. Naturally, if you happen to feel bad about something, you do not tell her about it, because she feels worse than you do. You allow her to depend on you, not vice versa, because you

already have sources of support, whereas she does not. The manager has already assigned someone as a primary helper until the new mother makes friends. If the case notes do not yet show that mother knows and feels free to contact the primary helper and manager, be sure that she has this information. Either enter it or have her do so (see notes to manager). With the above purpose in mind, you may perform any or all of the functions below at the request of the manager, the module coordinator, or the project coordinator.

Introducing parent to Project. As you recall, after the staff determines that a family needs Project help, we try to show parents what they will be involved in before they make a decision on participation. We feel that this can best be done by a parent who has dealt successfully with similar problems. Therefore, in cases that will probably go into oppositional child training, you might be asked to show the prospective participants around. If you are, talk to the parents quite openly. Answer any questions they might have about RIP. Give reassurance if you feel you can honestly do so. Perhaps the most effective reassurance method is indirect. Rather than telling the parents, who may be discouraged or inclined to reject advice, what will occur with their child, describe in general terms what did occur with yours. That way you know you are correct. You are making irrefutable statements that indirectly, but clearly, indicate you understand their problems.

Do not give any treatment advice or any specifics of the techniques of intervention with oppositional children. They would surely be misapplied. Moreover, without knowing the case, you could be wrong, and that would be punishment of the parents' new responses. Also, without a baseline, we are not sure regarding the problem. We have simply made an intelligent guess. Finally, giving technical information could distort the baseline and prevent accurate assessment of the problem.

Explain that the training is set up to consist of 20-minute play sessions with parent and child, two minutes on each of ten toys. Show playroom, observation room, playschool, preschool, and individual tutoring. Answer questions freely. If a parent who is beyond baseline happens to be in a session in the playroom, limit observation to one minute to prevent imitation, which would distort baseline data. Describe Thursday parents' class, which is attended by every parent in the program. Explain that at least mother will attend regularly as soon as baseline is completed. Return parents to person doing the intake as arranged when you met them, reassuring them that you know they have only a general impression. At a later date, the manager of visitation will take the mother or both of them on a thorough orientation tour.

Toys used in sessions. A standard list of ten toys is used in all sessions. This list includes a ball, a family shoe, nesting cups, blocks, a xylophone, two trucks, some pots and pans, a stack chip tray, a balance scale, and a puzzle ball. The toys are all manipulable; have many possible variations or uses; are small enough for convenience of storing; are suitable for indoor play; are not too passive or conducive to parallel activity at a distance.

Case folder. The secretary will compile the folder after she has been given the new client's name.

Confidentiality. Have clearly in your own mind and be prepared to convey to the new mothers our policy on confidentiality. That is, although the usual standards of professional confidence apply in RIP, they apply to the parents and to the children's medical doctors as a group rather than to an individual. Typically our parents know a great deal about one another's children's problems because only with this knowledge can they effectively help one another. Decisions about seeking or conveying information are made on a "need to know" basis. Outside the Project, RIP parents do not discuss or identify one another.

Convey to the new mother the gist of the following and provide her with the details of some personal experiences. "Whereas Project policy forbids your mentioning or identifying other participants, your decision to relate to your friends and neighbors your participation in oppositional child training must be your own. However, maybe the experience of others can help you. The experience of some of the parents is that some neighbors, upon finding out their children were in a special program at the Kennedy Center, immediately began to think the children were emotionally disturbed, incorrigible, possibly dangerous, and probably to be avoided. Any minor neighborhood mishap involving the child was automatically interpreted to be his fault, and surely a symptom of the child's 'disturbance.' Not all parents have experienced this by any means, and few, if any, have any reservations about being identified as RIP workers after the problem is solved."

As a parent functioning as a technician, you typically have access to detailed information and to areas of concern that otherwise would not come to your attention. Follow the guideline of dealing with the technical problem and seek information relevant to it only. Do not ask a client for personal information except as it relates directly to the case. Record such information in the work folder (or have mother do it herself), which will ensure that it will be seen by the other technicians who need to know, but by no one else.

Sometimes new mothers are under considerable strain and may talk about problems other than those with the child. Sometimes personal information, such as a fight with father, may directly influence the case, perhaps leading to a poor session. In these instances listen acceptingly and without judgement. Report the content to the module coordinator. If pressed for an opinion, outside your training in the Project, disqualify yourself and describe some differences between friendship and treatment, offering friendship. If in

doubt about how much to record in the case notes, consult with the module coordinator. In her absence, make up two notes, one with full information marked "confidential" for her attention and the child's chart, and one containing only technical data, etc., for the work folder.

As a technician, use your common sense. If a mother would just as soon not have revealed some facts that she did convey when she was distraught, pride yourself on your bad memory. If you at any time feel doubtful or uncomfortable about a situation or about a new mother, request staff assistance. Say nothing except to the module coordinator.

In the first baseline session, show the mother the work folder and explain that it contains no forms or records from other agencies. These and similar materials are in the main case folder, to which the parents do not have access. When a child no longer comes to the center, the work folder is incorporated permanently into the case folder in the locked file. Relating this information may provide a graceful way into a discussion of the above points on confidentiality. Since the mother will have this text, you can assume that she will have a general idea of your functions, but it is wise to also assume that she may have some questions and some doubts. Your openness in discussing this matter and others relevant to the case will provide her a pattern to imitate.

Control of extraneous variables. Cases will go more smoothly if the training situation and events leading up to it can be held as constant as possible. For this reason mothers are asked to come in not more than one-half hour before the session begins. Unless a father or other visiting family member come every day, prevent the child from knowing they are there. If they came in together, they should be kept separate until after the session. Guard against other unusual setting events. Becoming involved in play with

other children in the hall is an example. The child is not allowed in the playroom before the session begins. The general rule is to hold all factors constant except the one which we are manipulating in training.

Baseline instructions. Giving baseline instructions assumes that all the instructions above have been carried out. The mother may be caused unnecessary stress if they have not. Prior to the first session read or repeat the following text. "As you know, your job is to play with your child and get him to play with ten different toys in the order listed on the board. Don't feel humiliated if you have trouble. The frequent changes are designed to provoke opposition. By analyzing it, we can help you. Just try to get him to play with the right toy by using whatever methods you usually use or whatever method you think will work best.

"When you walk into the room begin with the first toy listed on the chalkboard. From then on we will signal you when to go to the next toy on the list by turning on the little light that shows through the observation window. If you do not notice the light within ten seconds, we will tap lightly on the window, so don't worry too much about watching for it.

"By the way, it's not necessary to put one toy away before going on to the next. Such things are up to you.

"Do you have any questions?" (The answer to virtually all questions will be "It's up to you," or "Just do whatever you usually do," or "Whatever you think is best."

After the session, inquire to be sure mother is working on her Project forms. Give out Intervention I section after last baseline section.

Manager

Upon being informed that new parents have signed in, assign a trained couple for primary support. They are to phone and to visit if they would be welcome on the afternoon or evening of intake. Arrange for opening of case folder and first appointment if these have not been done.

In oppositional child training the manager performs in addition some operations that are handled elsewhere in the Project by personnel who have case responsibility. As manager, inform the Project Coordinator of your estimate of when the new mother will finish baseline and mention any delays. Note the beginning of intervention. This signals that the mother can begin participating in the Project, attending Thursday's parent group, and studying learning theory. The new mother will be ready for an orientation tour of the rest of the Project at this time.

Module Coordinator

The following list outlines the functions that must be carried out within the service module. The coordinator's primary responsibility is to ensure that the functions are clearly assigned, thoroughly understood, and well carried out, as measured by rate of child behavior on the graph. The probable clustering of functions is indicated, but it must be understood that functions will be reassigned in accordance with shifts in personnel, following the principle of utilizing available strength. To group functions permanently is to create roles. The creation of roles in RIP would be an organizational error resulting in problems of replication and concentration on remediating weakness in filling a role.

A secondary function of the coordinator is to assume the role of the professional if the dependency needs of individual clients so require, but if the assumption of the role is carried beyond this use, the functions implemented by others will be weakened. One immediate result will be a work overload on the coordinator.

OPPOSITIONAL CHILD TRAINING

FUNCTIONS WITH DESCRIPTIONS AND

PROBABLE ASSIGNMENT

1. Show Project to prospective participants.
   (Technicians and Manager)

2. Support clients.

   a. Primary helper (reactive).
      (Technicians)

   b. In depth as assigned (active).
      (Manager and Module Coordinator)

3. Create setting for data taking.

   a. Open folder.
      (Technicians)

   b. Prepare playroom.
      (Technicians)

   c. Get and set up equipment.
      (Technicians)

4. Count behaviors.
   (Technicians)

5. Record counting.

   a. Data summary.
      (Technicians)

   b. Graph.
      (Technicians)

   c. Rater reliability.
      (Technicians)

6. Check counting and recording for accuracy.
(Manager and Module Coordinator)

7. Feedback to clients.
(Technicians)

8. Model proper behavior for clients to imitate.
(Technicians)

9. Ensure that clients know what to do.

   a. Give Baseline, I-1, Reversal, I-2 instructions at proper time.
   (Technicians)

   b. Make home assignments.
   (Module Coordinator)

   c. Teach measuring.
   (Module Coordinator)

   d. Teach and explain theory as applies.
   (Technicians, Manager, and Coordinator)

   e. Assign programs.
   (Module Coordinator)

   f. Teach how to write case notes.
   (Technicians)

   g. Impart knowledge of "tricks."
   (Technicians)

   h. Make sure clients know how to generalize.
   (Technicians, Manager, and Coordinator)

*10. Positively reinforce adaptive changes in parents.
(Technicians, Manager, and Module Coordinator)

11. Monitor parents' perceptions of home changes.
(Technicians, Manager, and Coordinator)

12. Impart knowledge of all functions to new technicians.
(Technicians)

13. See that functions are done by person assigned.
(Manager)

14. Arrange appointments and schedule technicians.
(Manager)

15. Apply behavioral analysis.
(Module Coordinator)

16. Make case decisions.
(Module Coordinator)

17. Handle problems that exceed system.
(Module Coordinator)

18. Make a treatment summary and review.
(Specialized Technician Function, Module Coordinator)

19. Check and ok report.
(Coordinator)

*New mothers usually begin with this technician function as they spontaneously applaud each other's successes.

Intervention I (Distribute after last baseline session)

We have kept you in the dark until we reached an understanding of your difficulties, but now the suspense is over. We are going to do something about them. If the coordinator feels that you have any additional problems, she has discussed or will discuss them with you privately. Beyond that, the picture we have obtained is the same as in all previous cases. Your attention to the child is non-contingent. It does not depend on what he does. This is, whether the child is being good or whether he is refusing in some way to follow your instructions, you are touching him, looking at him, talking either to him or in his presence, and generally being "with" him. That's the problem.

We understand that you have varied the content of your attentive behavior, but you have been misled by focusing on the content or the form of your behavior. We have overwhelming scientific evidence from laboratories, clinics, and schools all over the country that the timing of your attention, not the apparent content or form of it, controls young child behavior. Why this should be so is probably a mystery to you now. By studying the explanation given to you, and going through the Project's theory course, you will come to understand. You will also come to understand that your problem is just one of the possibilities resulting from our culture's normal, non-scientific childrearing patterns and that having it shows, believe it or not, that you are a better parent than most. Such eventual understanding is necessary for you to be independent of us, but you joined RIP to change behaviors, so we are going to start doing just that in your next session.

You are probably studying this pamphlet at home. We know that you are eager to get some results with your child, but we must insist to protect your child that the following information is not to be applied until after you have received instructions at your next session. Please study carefully and try to comprehend

the principles. Write down any questions you have, because you may forget them when you come to the center. Do not attempt to use the techniques yet.

The technique you are about to learn is called "differential reinforcement." That is a fancy, but short, way of saying that you attend to different behaviors in different ways depending on whether you want to see more of them or not. The technique depends on the principles of positive reinforcement and withdrawal of positive reinforcement. Starting in your next session, not before, but then everywhere and at all times, attend only to desirable behavior. As your technique of positive reinforcement, when the child is playing with the appropriate toy "turn on" at once. Talk to him, praise him, describe and label what he is doing (teaches vocabulary and concepts), smile, touch him, play with him, give him any form of attention you naturally give. If you have trouble "loosening up," the other parents will model these behaviors for you to imitate.

On the other hand, as your technique of withdrawal of positive reinforcement, in the split second that you see refusal to follow instructions or other behavior you want to get rid of, such as throwing objects, crying, whining, nagging, etc., completely "turn off." Do not look at the child, touch him, or speak. Do not play along with something else. Do not play with the toy he is supposed to play with. Move completely away from him and either watch him out of the corner of your eye, or in the mirror, but in such a way that he cannot see you do it. In other words, ignore him completely and that is all. You will soon begin to hear of other techniques of withdrawal of positive reinforcement, like isolation, from other parents. That is fine. We want you to understand what they do and why they have to do it. You are never to apply such additional techniques without the permission of the module coordinator. Our experience to date indicates that they are seldom needed with very young oppositional children.

Because we cannot say it too often, we will say again here that the above techniques for the playroom and everything else in the Project are designed for the single purpose of teaching you what to do at home and helping you practice it. Your child's behavior at home will change only if you apply at home what is learned in sessions. At first, in sessions and at home, his behavior may very well worsen. Do not expect it, but do not be surprised or upset if it happens. After all, to some extent you have stopped doing what you used to do to control him, but the new techniques have not started to have an effect yet. You never respond to a worsening of behavior. To get through the transition period from old to new ways the program must be applied consistently. Furthermore, the attention-timing techniques you are learning are very powerful and they must be applied exactly as instructed. If they are not, for reasons you will study under "shaping" and "intermittent reinforcement" you can create some problems that will make you think your present situation was a holiday. You respond to nothing except your child's return to desirable behavior, which in the playroom consists of playing with the designated toy with no crying or whining. The instant that he resumes appropriate behavior "turn on" in the playroom and, especially, at home. Talk to him, make approving comments about his playing, smile, sing, laugh, describe to him what he is doing.

Check with the technicians first, but if you have other young children you will probably want to include them in these techniques as well. It is wise not to set the oppositional child off from the rest of the family. If the other children are not a problem, then they can only gain in attention from you by being included. On the other hand, if they are not included, the extra attention being given one child and any resultant ignoring of them might lead to their starting to misbehave. See if you can deduce from the theory below how it could happen.

The following theoretical outline sketches in the origin of your difficulties. In order to understand it thoroughly you will need to have studied the materials on page 29. For the time being, go back and forth to your "Important Concepts" paper when you are puzzled by a technical term like "extinction."

The development of a normally-behaving child into an oppositional child is seen as a changing behavior interaction. Specifically, it has been described by researchers as a period in which bad behavior feeds upon itself. The rate of bad behavior increases, drawing the parents' attention. Therefore, at the same time, the rate of appropriate behavior declines. This cycle progresses through increasingly annoying oppositional interactions. It may begin gradually at any point after birth. Usually the cycle begins with normal behaviors that occur in the child's interactions with his physical environment. Psychologists have reviewed how parents may shape or increase aversive infant behavior through conscientious caretaking, such as attending to normal crying. In general, the parents, since they have no specific definition of developmentally normal behavior, may not attend to desirable behavior often. However, they consistently attend to normal but undesirable behavior because often it is life threatening or highly annoying. Examples are: screaming when hungry or wet, chewing electrical cords, throwing food, exploring stove burners. This differential parental reinforcement of the child's desirable and undesirable behavior is critical, for it serves to increase undesirable behavior. As the child develops, the emotional behavior (like tantrums) that follows the interruption of undesirable behavior is increased, thus changing the nature of subsequent interactions.

After the child begins to move about, the parent finds himself concerned with an increasing number of inappropriate behaviors. As a result, he watches the child's behavior more closely in an effort to guide it, soon perhaps experiencing emotional responses from realizing that the child often looks to be sure

that he is observed before misbehaving. This increase in parental attention may be followed by a higher overall rate of child behavior or a higher rate of changing from one activity to another. Stimulation from constant frustration and/or inherited tendencies may also add to the child's high activity level. (The practice of giving medication to the child is thus seen as reducing the frequency of symptom occurrence at best.) As the interaction deteriorates, the parent may become exhausted in attempts to pacify or guide the child by constant supervision. The parent may snatch needed relief during periods of appropriate behavior, thus putting the good behavior on extinction. But because the parent still has to attend to bad behavior, its rate is further increased.

As the parents' differential reinforcement of the child's bad behavior develops the bad behavior further, there may be little time left for anything else. Parent contact with the growing child may become a constant battle or struggle from the parents' point of view. From the behavior analyst's point of view, most parent contact with the child now consists of aversive (unpleasant) oppositional interactions. As a result, the child or oppositional interactions with him may become an aversive stimulus to the parents. That is, they start to avoid the child. Indeed, the parents of oppositional children under 36 months often say that they are seeking help in dealing with the child's bad behavior not only because of the behavior as such, but especially because they are worried over beginning actively to dislike the child. As a result, they may start paying attention to him only when his behavior goes beyond a tolerable limit.

If his parents attend to him mostly when he is doing something they cannot stand, the child may be almost without positive parental attention. When this happens, he may actually work to get scolded, spanked, nagged or whatever. Although these interactions appear very negative and upsetting, in technical terms a change in stimulus function has occurred. The child really misbehaves in order to be punished.

(The professional reader will recall that Gewirtz has discussed such changes in stimulus function and that reinstatement of positive parent-child interactions during training would account for Wahler's (1969) JABA data on increase in parental reinforcement value after treatment periods. That is, the effective elimination of parent-reinforced oppositional behavior and the substantial increase of parent reinforcement for cooperative or appropriate behavior would tend to reestablish the parent as a conditioned positive reinforcer. Similarly, the child would again become a conditioned positive reinforcer to the parent as reported by Bernal and as our parents have reported.)

If the parent continues to avoid the child, attending only when bad behavior is more than he can put up with, the child's bad behavior will be shaped to its most persistent and annoying form. Because the parent is attending to whatever is new and bad, new forms of bad behavior may emerge. In children of grade school age predelinquent and delinquent behaviors such as firesetting, stealing, and vandalism may occur.

The development of the oppositional syndrome at intervention should give information predicting the educational procedures that will be required. For example, positive reinforcement plus extinction procedures are usually effective for the infant or very young child who is on a continuous schedule of parental reinforcement. When, because of parental avoidance and reinforcement patterns, the child experiences a high intermittent schedule of reinforcement for an extensive repertoire, a treatment procedure incorporating isolation rather than simple ignoring may be more efficient. If the child has an extensive repertoire obtained in part through symbolic models such as television and newspapers, then measures such as isolation and punishment may be not only more efficient but more effective than simple extinction.

By now you may be starting to perceive that the term "oppositional child" does not accurately describe your situation. We use it partly because it is traditional, but mostly because our language has only cumbersome phrases that would describe the real problem, such as "timing of child-environment interactions." Through no fault of yours, the problem lies not with your toddler and not with you, but in the interaction between you.

To change an interaction one has only to alter the behavior of one party to it. Your child neither reads nor understands complex verbal instructions. He does not work for long range, intangible, or delayed goals. He does not make symbolic comparisons (such as between his behavior and his brother's). He does not control the resources of the household. You do. Therefore, we change your behavior in order to change the interaction and its components. Your child will quickly learn that to get your attention, and many of the life-sustaining resources to which it leads, he will have to behave in an appropriate manner. Beyond that, the character of your interactions will change. The steadily worse cycle you have been in will shift into a steadily better cycle of interactions, with you praising because you are genuinely delighted with your child and your child enjoying life as a natural response to your affection.

At first, it may take a lot of restraint on your part to ignore some of his behavior. No one likes waiting out temper tantrums! There may also be some times when you cannot ignore, so we anticipate your discovering this and offer the following three categories of behavior, with instructions and forms for lists.

Behaviors that cannot be ignored. You cannot ignore behaviors that may kill or permanently maim your child or others. Running into the street is the prime example. Make a list first. (Use form on next page.) Then, until we write programs for the technicians to use, consult with the module coordinator on what to do.

BEHAVIORS THAT CANNOT BE IGNORED
(Note dates on each behavior)

BEHAVIORS THAT BUG YOU

OTHER UNDESIRABLE BEHAVIORS

There is another category of behaviors that you cannot ignore that we discuss here to save the coordinator's time. They stem not from the child or your interactions with him, but from an unrealistically engineered environment. To invent an example, we refer to the genuine, flawless, fragile Whippydip-period Whidgit that you inherited from your Great Aunt Suzy because you were her favorite relative. To expect your child to refrain from banging on it, shaking it, playing on it, and generally giving it treatment that it cannot withstand is unrealistic. He is a child. Remove it or him from the situation. That is, close the doors to the room, put up gates, put the whidgit up, or put the whidgit in storage. Rest assured, the Grandee who had it made did not let his kids into the same wing of the castle with it. That is why it lasted. Or, if it is an antique that was once in normal household use, remember it was not an antique <u>then</u>. For every whidgit that survived, 1000 were smashed.

Seriously, we suggest the following maxim. "It is sometimes easier to change the environment than to change the child." Being ingenious behavioral engineers, we can program your two-year-old not to run out the back door. Having plenty of urgent use for our ingenuity, we can also suggest that you install a slide bolt up out of his reach and have done with the problem in five minutes.

<u>Behaviors that bug you</u>. This is a borderline category. For example, once you have removed the whidgits, you probably have over 99% of your furnishings left. Although resigned to a normal number of bumps and scratches, you probably do not want them destroyed. On the other hand, some people do not care. Hence the question of the reasonableness of your views may arise. In general, we will help you deal with behaviors that a lot of people you know would consider inappropriate. Add to your list the behaviors that you cannot stand.

To save ourselves work, we include here the remedy for a number of behaviors probably on your list. They fall in the general category of "child acts on his surroundings with an instrument, threatening destruction of either environment or instrument or both." For example, your child discovers that his corn popper not only pushes and pulls, but swings like a sledge hammer--against the coffee table. Or, having come into possession of a toy hammer, like any human given a new tool your child decides that everything around him needs hammering. Or, after playing appropriately with his new truck, he begins to pound it on the floor--or on the baby. The solution is as general as the problem.

If you only find evidence that the behavior has occurred, ignore it. (Remember, this and some of our other techniques are specific to children under 36 months. You will purchase a text to cover your child's development through grade school at the end of training.) We assume that your child does not yet have the ability to connect a past event with the present consequences. Therefore, all you could do by scolding in these circumstances is teach him to be afraid of what is present--you--because his main behavior at the time you find the evidence will probably be to approach you.

On the other hand, if you find the behavior in progress, give one two word command. Give it forcefully, always the same, and without anger. "Stop that!" If the child does not obey within five seconds, matter of factly remove the instrument, without anger, and, without further comment (no attention!) put it up out of reach for 24 hours. Ignore the resultant howling. Later, the child may request the instrument. This is appropriate, adaptive problem-solving behavior on his part. Often the two-year-old is changing over to a greater ability to comprehend reasons, so respond by attending to the adaptive behavior, but take into consideration his developing ability to be controlled by the content of your attention. That is, explain why you put the instrument up and, in terms

of his conception of time, how long it will stay up (e.g., "till when you get up from being night-night"). You are dealing, however, with a child whose conception of causality and control is external. In his view, the truck hit the baby. He did not. The chances are good that he will resort to nagging, whining, or a tantrum despite your reasonable explanation. Ignore these undesirable behaviors. And the instrument stays up for 24 hours no matter what.

Our general approach is to use your specific problems as illustrations of the principles of behavior management so that you can deal with new situations on your own. Conceptually, the solution given above to the child and instrument problem is analyzed as follows: Child emits behavior which is S^D for negative reinforcement to parents. Parent emits clear, invariant avoidance behavior, "Stop that!" Child does not respond. Parent interrupts child's activity, putting instrument up, but giving as little attention as possible. This amounts to parent withdrawing a positive reinforcer from child, while bestowing as little positive reinforcement as possible. Behavior which results in the loss of a positive reinforcer decreases in frequency. Hence, a number of results occur. First, the overall rate of inappropriate child and instrument behavior may decline slightly. Second, the rate of inappropriate behavior with that particular instrument will probably decline somewhat. Third, the phrase "Stop that!" begins to become discriminative (S^D) for the loss of positive reinforcement in such situations. Such S^D's acquire a secondary negative reinforcer function. That is, your child will avoid them by playing appropriately with the instrument. Conversely, when the S^D's are presented, they decrease the rate of ongoing behavior. Thus, after your S^D has led to the withdrawal of a positive reinforcer often enough, when you tell your child "Stop that!" --he will, because, in the technical (not the everyday or cultural) sense, you are punishing his ongoing behavior.

No doubt you find the above paragraph very difficult. Return to it later as you progress through your readings until you comprehend it and can explain it to others. We hope that the instructions which precede it are clear and that they will deal with your list of the behaviors that bug you. If they do not seem to, consult with the module coordinator.

Other undesirable behaviors. This third category should contain a variety of behaviors that you dislike, but can tolerate (with effort). Add them to your list so that you are quite clear on what they are. Now make sure that you and your spouse agree on what behaviors are in what categories. When you do, copy off one list for him and one for us. Bring two lists with you at the next session so that one can be clipped into your work folder, and you can make notes or changes on the other if necessary.

The "other undesirable behaviors," and the ones that are not worth listing as well, are to be ignored. Such a program would be inadequate in itself, but because you are practicing giving a rich schedule of attention to your child for desirable behavior, his miscellaneous undesirable behaviors are going to decrease rapidly in frequency. In the meanwhile, until your new contingent timing of attention becomes habitual, think of yourself as a machine designed to respond to child behavior with warm, loving behavior. Desirable behavior on his part activates the machine. Undesirable behavior on his part turns the machine off or even sends it away. Under the occasional child-and-instrument circumstances discussed above, the machine emits one warning, "Stop that!" It then either removes an instrument or turns on again. Being an efficient machine, it is not programmed to emit the useless behaviors that our culture calls "punishment." (See "Notes from a Lecture on Punishment." There are to be no more spankings without prior permission of module coordinator.) When the inevitable childhood illnesses come, the program is basically the same. Check with the coordinator

when the child becomes ill so that she can specify changes by your child's individual needs.

Because application of the above techniques may be awkward or forced at first, parents sometimes ask how long they will have to apply the principles of reinforcement. The answer is for life. You can stop planning or stop consciously applying the principles, but the fact remains that so long as you interact with an environment, including your child, your own behavior and the behavior of those with whom you interact will be influenced reciprocally. In other words, you may ignore the effects of reinforcement, but they will still be there. In general, our view is that parents should take responsibility for their children's behavior rather than leaving it to chance, other children, the schools, or the TV set. We cannot force such a view on you. You have a right to your opinions. During the period of intervention and consolidation of what has been learned, however, we are providing help that you have requested. Therefore, we can (and do) insist that during relearning and consolidation you know what behaviors you do and do not want from your child and reinforce accordingly.

In addition to the above techniques, we would like to stress the following. It is very important to offer food or drink during times when the child's behavior is good. For instance, if the child screams or has a tantrum demanding his afternoon snack, even if it is time for the snack, ignore the screaming or tantrum. Wait until the child is quiet and well behaved. At that time you may pleasantly announce, "It is time for your snack." If by chance your child should begin another tantrum, you must wait again until he is quiet before offering it again.

The above is included because food is a powerful reinforcer of behavior. It is important to offer it during times when the child's behavior is good. Otherwise, the food will act as a reinforcer for the bad behavior. Sitting quietly is acceptable behavior before the food is offered. If, for instance, the child

sees you pouring his juice and in the excitement of it begins to roar through the house, wait until he is sitting quietly before you offer the juice. You may say once, "When you sit down, you may have the juice." If you offered juice immediately after the child had run through the house, you would unwittingly have reinforced running through the house. Levels of running through the house would thus increase. If you offer juice when the child is sitting quietly at his place, that would be a reinforcer for sitting quietly. Levels of sitting quietly would thus increase. The importance of timing food and drink to be offered right after good behavior has occurred cannot be over stressed. Do not ever offer food to "shush up" the child. If you have any questions about this explanation, please ask the module coordinator.

All the above may sound quite simple. Just ABC for the difficult problems you have been having.

To the behavioral scientist the problems are simple. We fully understand, however, that you are going to have to exercise great patience and consistency as well as some ingenuity in transferring what we teach you to your individual home problems. The technicians will help you. That is what they are for.

To help you learn the new techniques, we have a special videotape prepared for you to watch. Our media module manager will show you videotapes of other mothers who have learned good techniques. She will arrange a time for you to observe after you have completed Baseline.

Let's go to work!

Technicians

The purpose of intervention is to enable the mother to generalize what she learns to the natural environment. Your function is to guide her by helping her understand her readings, by helping her with home and session problems, by

relating solutions to general principles, and by positively reinforcing adaptive changes in her behavior.

Provided that the mother has turned in her Project forms to the secretary, after the last baseline session (determined by module coordinator), give her this section with instructions to read it before her next session. Assume that she will do so; do not ask if she will. The laundry or a visit from grandma can wait a day. Also give her "Important Concepts," "Punishment Lecture," and "Social Reinforcement Technique" papers. A fourth booklet, The Analysis of Human Operant Behavior can be purchased for $.85 at a bookstore. If it is not available, it can be ordered from William C. Brown Company Publishers, Dubuque, Iowa.

She is to study them in the following order:

IMPORTANT CONCEPTS

PUNISHMENT LECTURE

REESE: THE ANALYSIS OF HUMAN OPERANT BEHAVIOR

SOCIAL REINFORCEMENT TECHNIQUE

She should repeat the "Important Concepts" paper at the end and refer to it as needed.

Inform the manager that the case has gone to intervention.

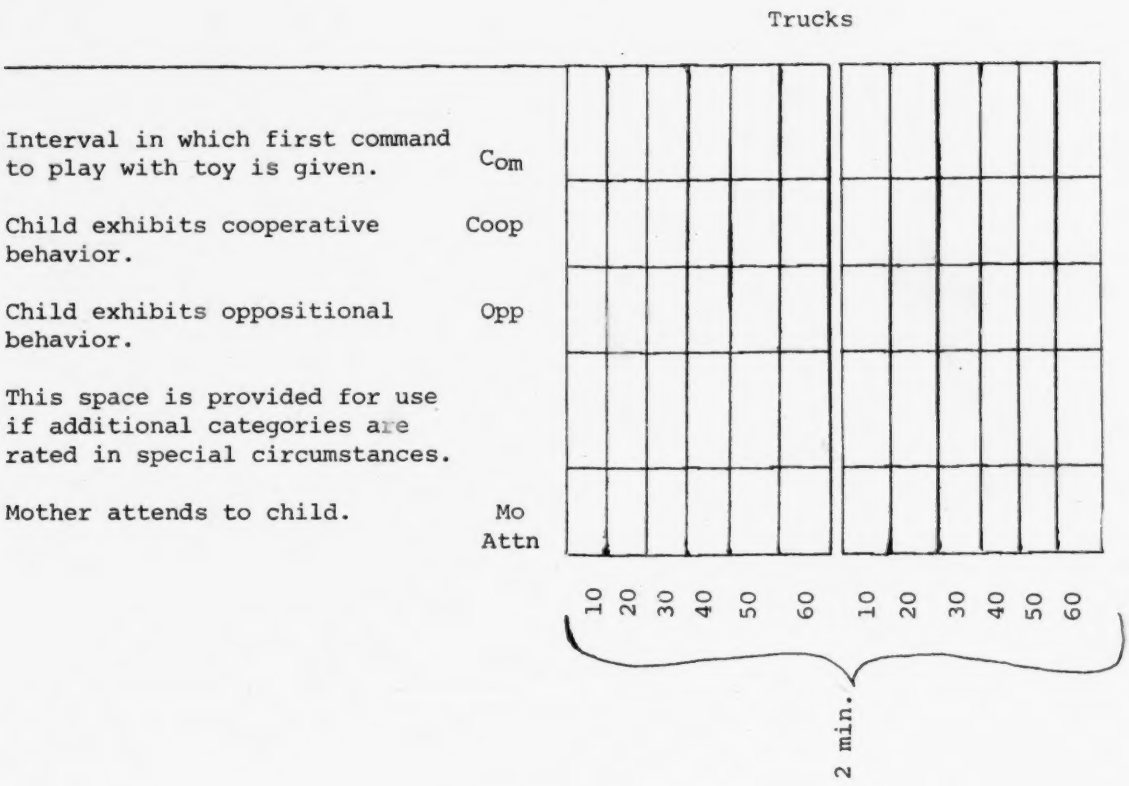
Prior to the first intervention session, speaking slowly and calmly, answer questions the mother may have from her reading. Go over the baseline graph with her. Repeat the instructions for changes in her behavior given earlier in the section. Use examples from baseline incidents. Model for her how to describe the child's ongoing activities in terms the child will understand (as a means of cognitive development-oriented positive reinforcement). Stress the importance of timing and show what you mean. Instruct her to change her form of command to "Now it's time to..." or "Now we're going to..." and to restrict

herself to only two or three sentences to try to get child to switch. Ask if she has any questions. Run the session, reassuring her that we do not expect her to be perfect.

After the session, give feedback. Instruct the mother to have the child help her clean up the room before leaving. Begin teaching her how to write up her own case notes, and explain to her that after baseline, at the end of each session, she writes up her own case notes on the sheet marked "Contact Sheet." These remarks should include anything she considers pertinent about the session or any event that preceded it. They should also include any special instructions she received before or after the session. Any home assignments made should be noted. This includes counting assignments and definitions of behaviors to be counted. She should also mention any particular problems, improvements, or changes in her home situation. The additional work of teaching her will soon be over; it is well worth the effort because it provides you with feedback about her comprehension.

Manager. Using main checklist in folder, give out listed pamphlets to mother and inform Project Coordinator, In-Service Training Director, Visitation Manager, and Media Manager that client has completed Baseline.

Computation instructions


Trucks
Interval in which first command to play with toy is given.
Com
Child exhibits cooperative behavior.
Coop
Child exhibits oppositional behavior.
Opp
This space is provided for use if additional categories are rated in special circumstances.
Mother attends to child.
Mo Attn
10 20 30 40 50 60 10 20 30 40 50 60
2 min.

The twenty minute play session is divided into 120 ten second intervals. These are grouped in 20 blocks, each of which includes six intervals. As the session progresses in time, the technician rates whether the child is being cooperative or oppositional during each ten second interval. If the child is both cooperative and oppositional during one ten second interval, two marks are checked, and that interval is termed "mixed."

Count the intervals of oppositional behavior for the entire 20 minute period and enter the total on page 1 of the rating paper under "Child's Behavior" in the square marked "Rater 1." A mixed interval is counted as oppositional since only oppositional check marks are counted.

Next, the intervals during which the mother attends to oppositional behavior are counted. The total is entered on page 1 under "Mother's Behavior" in the square marked "Rater 1."

Under "Child's Behavior," the total intervals of oppositional behavior are then converted to a % using the conversion table. This percent is entered following the phrase "Above mean converted to %." This is the number that is graphed by a red dot on the graph in the child's folder. It represents the level of oppositional behavior exhibited by the child during the session.

The percent of oppositional behavior is then subtracted from 100. The answer is the percent that is graphed by a blue dot on the graph. It represents the level of cooperative behavior exhibited by the child during the session.

Under "Mother's Behavior," the total intervals of attention to opposition are converted to a percent using the percent table. This percent is graphed as a black X on the child's graph.

If there are two raters rating the session, Rater # 2's totals are entered in the proper boxes, and the average or "Mean" of the totals is the number that is converted to a percent.

To Check Reliability. To check reliability of two raters rating for the full 20 minutes, place the two papers beside one another. With a red pencil, go across the boxes and circle every difference on one paper only. Check the differences of cooperation, opposition, and mother's attention. The command is not a part of the reliability check.

After all the differences have been circled, go back and add up the number of times you differed on cooperation and place the total in the appropriate space on page 2 of the rating sheet. Do the same with opposition and mother's attention. Add these totals and subtract from 360 (this is the total number of intervals you

could differ). Divide this number by three and convert the answer to a percent using the table. This gives you the percent of overall reliability.

If Rater # 1 rates for 20 minutes and is spot checked by Rater # 2 for 10 minutes, the total number of differences are subtracted from 180 (the total number of intervals you could differ). This number is divided by 1.5 and the quotient is converted to a percent using the table.

CHILD'S NAME_____

Child Behavior RED BLUE (Mother Attention to) BLACK X

Date	Ses.#	Cond.	Adult	Cum. Min.	Opp. & Mixed Intervals	% Opp. + Mixed	100 - Opp. + Mixed	Opp. Intervals	% of Opp. + Mixed	% of Rater Reliability	Initials Rater I	Initials Rater II
These columns are self-explanatory. Under condition column your chart will need to show which conditions have been added to experiment- ~~e.g., Baseline I, II, III, Intervention I, II, Reversal, Etc.~~ Also note any variations (e.g., visitor in room).												
			This line, in our session, is usually the mother.									
				This line indicates a cumulative number of minutes, so you will consistently add 20 minutes unless there is a short session.								
					The two raters average (mean) of opposition and mixed intervals.							
						To get the % - take the number of opp. + mixed and convert to % using the percent table.						
							Subtract the % of opp. + mixed from 100 to get the % of cooperative behavior.					
								The two raters average (mean) of mother attention to opposition and mixed.				
									To get the % of mother attention to opposition - convert to % using the percent table			
										Sum of agreements over agreements plus disagreements for the two raters.		
											Initials of rater on light.	
												Initials of rater not on light.

OPPOSITIONAL TRAINING

CHILD_____ DATE_____ OBSERVER_____

TO TO

ADULT_____ SESSION NO._____ CONDITION B DR-I REV DR-II F

COMMENTS: (Last minute or special instructions)

CHILD'S BEHAVIOR			
Total intervals of oppositional behavior	Rater # 1	Rater # 2	Mean
Above mean converted to %			
			Graph red dot
Above subtracted from 100.	100 - _____		
			Graph blue dot

MOTHER'S BEHAVIOR			
Total intervals of attention to opposition	Rater # 1	Rater # 2	Mean
Above mean converted to %			
			Graph black X

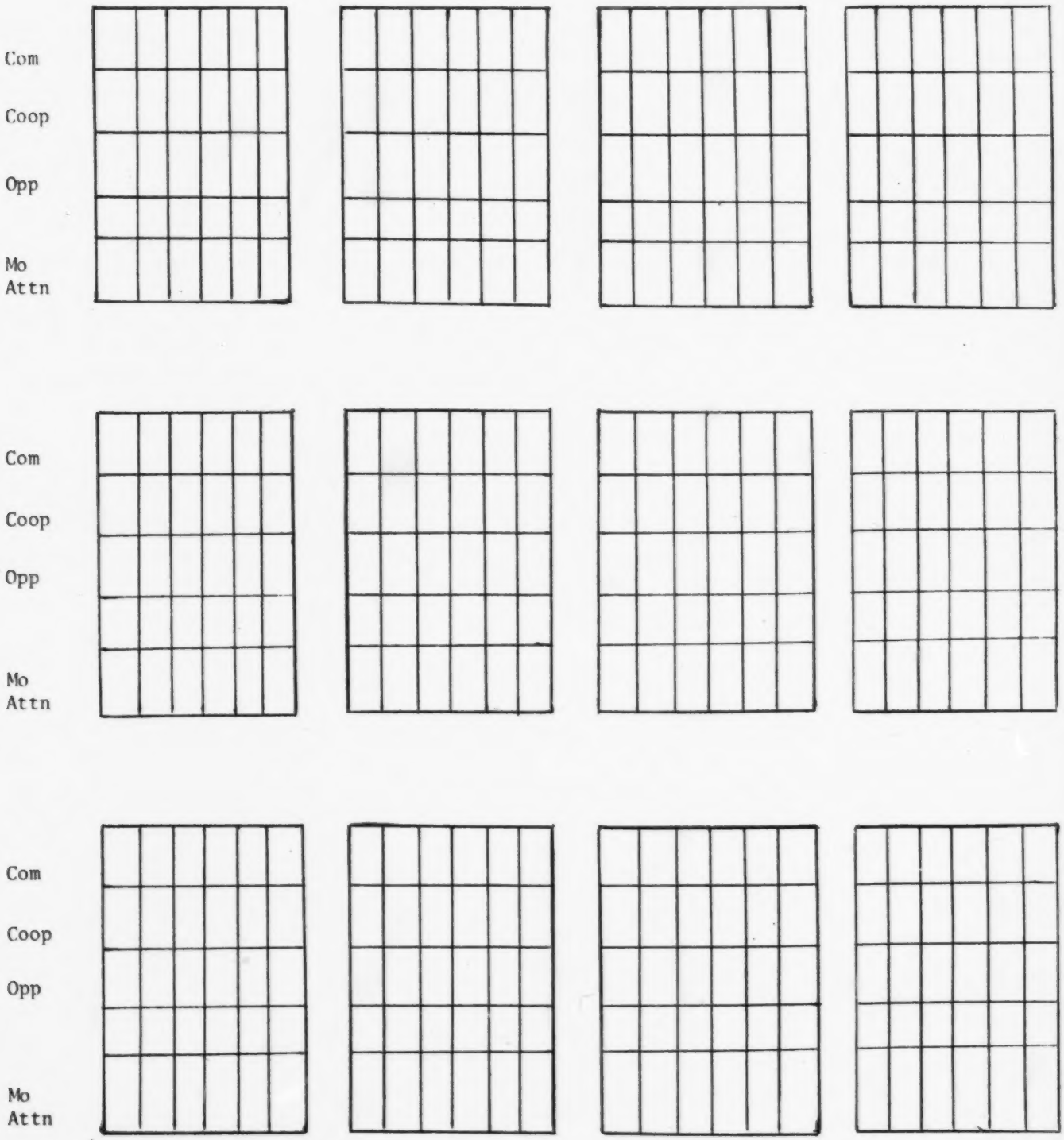
CHILD_____ DATE_____ SESSION NO._____ OBSERVER_____

RATER RELIABILITY (for 20 Minutes)	
Disagreements	
Cooperation	
Opposition	
Mother Attention	
Total	
Subtract above from 360.	360 -
Divide above by 3.	3⌐
Above converted to %.	

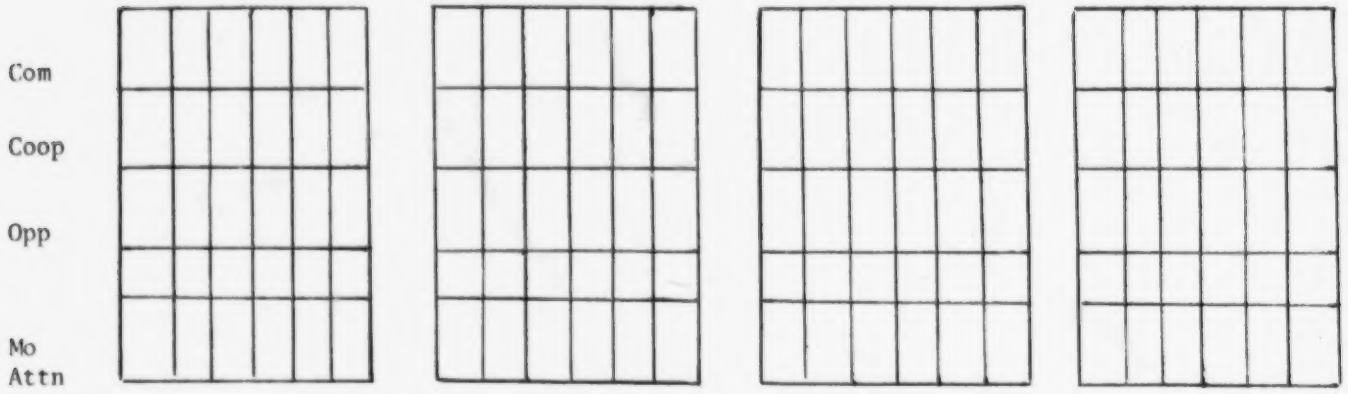
RATER RELIABILITY (for 10 Minutes)	
Disagreements	
Cooperation	
Opposition	
Mother Attention	
Total	
Subtract above from 180.	180 -
Divide above by 1.5	1.5⌐
Above converted to %.	

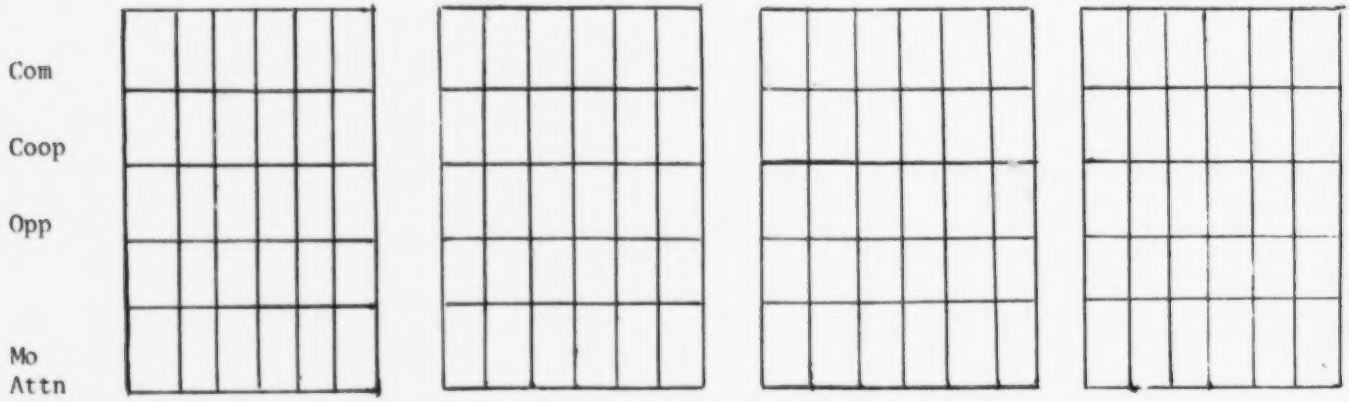
NAME OF DATA TABULATOR_____

CHILD_____ DATE_____ SESSION NO._____ OBSERVER_____



CHILD_____ DATE_____ SESSION NO._____ OBSERVER_____





Reversal

You have been doing very well with your child. Intellectually, you understand that the changes between you have occurred because you have altered the timing of your interaction with him. The time has come for you to grasp more fully that you can make of your child what you wish. The change in him is no mere accident of development, different activities, or our support. Also, you will be helped in future programming by having to think through and look at what you are doing now.

For the above reasons, in from one to five, but probably two, of the next sessions you will "reverse" your timing completely. That is, you will behave in the same way, but now you will attend only to behavior defined as inappropriate and ignore all behavior defined as appropriate. You will do this only in the sessions. The result will be that, in the sessions, your child's oppositional behavior will increase even beyond its base rates. The effect on him at home will probably be slight, if any. We are using a reversal rather than an experimentally more meaningful "return to baseline," in which you would respond in your old ways, because the results are quick and the complete switch of attention to the defined categories dramatizes our point: you are in command of the situation.

To the extent that you find the prospect of temporarily increasing oppositional behavior scary, or find yourself worried about recreating a monster or causing permanent changes in your child, the procedure is going to be extra valuable for you. Virtually all the technicians can give you instances of how it helped them.

Technicians

The reversal is a rare opportunity for the mother to see dramatic results from the changes in her behavior. Because the overall improvement in her child takes time, she may associate it with any number of irrelevant changes like improvements in physical health, her husband's new job, etc.. Remember, she does not have the scientific training that enables her to evaluate the research literature. Moreover, she is very likely focused on her own experiences, not scientific findings, as her guideline. The reversal procedure drives home the point that she has changed the child's behavior and that the concept of "cure" is inappropriate in her situation. Her child's behavior will continue to be what it has always been, a function of the timing of reinforcement.

If mother finds the prospect of reversal somewhat stressful, support her, but do not bother with elaborate reassurances. On balance, we would rather have her very conscious of the situation and alert rather than casual.

The module coordinator schedules reversal when the data show a downtrend in oppositional behavior and a level below base rate. Give the mother this section after her last Intervention I session. Inform the manager that reversal has been scheduled. Prior to the reversal session give the mother instructions that include:

During reversal do not give continuous commands. As during intervention, use only two or three sentences to ask child to switch toys. Then go ahead and attend to "inappropriate" behavior pleasantly. If the child does switch toys on command, the mother "turns off" completely, just as she would have if he had ignored or refused her request during intervention. She turns back on only when the child leaves the toy defined as appropriate.

A major point of reversal is the mother's having to think through just what she has been doing. She may need feedback after the session. She will probably

find discussing the insight she has gained very useful. Allow additional time before and after the session in your plans accordingly.

Manager

Allow some extra time before and after sessions in scheduling tasks. Be sure two trained raters are used immediately before, during, and after reversal, as these are crucial data points for case reporting.

Intervention II, Followup, and Generalization

Now that we all understand fully who controls whom and how (for the time being), we are going to move to more sophisticated, long-range programming. As you probably recall vividly, we first assessed your problem during baseline sessions. We then during Intervention I moved in to break up a pattern of deteriorating interaction by totally ignoring undesirable behavior and constantly attending to good behavior. We next during reversal removed any superstitions about the resulting changes and hopefully helped you better grasp what you were doing that was effective.

Next, we are going to bring your child's opposition score back down to around ten percent or less in sessions. This seems to be the level children hit when their parents are very happy with them at home. If a child never showed any opposition, we would worry about him. Such complete agreement with the world's unpredictable demands would be very peculiar. We will reinstate good behavior by exactly the same methods you learned in Intervention I. Review Intervention I.

Once the session interactions have stabilized at a low level of opposition, we will reduce the frequency of sessions, at first to once per week, then to once per month. Followup will continue for 6 months from the commencement of weekly sessions. During this time you will be working very hard on a number of things that are an integral part of the relearning you have undertaken in joining the Project.

First, as soon as your child's oppositional behavior declines to low levels both in sessions and at home, you will continue to ignore undesirable behavior completely. Also, however, you will very gradually start to ignore some of his good behavior. That is, you will gradually begin to fade or "leave out" your positive reinforcement of good behavior to an intermittent schedule of reinforcement

that you feel comfortable with. As we hope you know by now, reinforcing behavior on an intermittent schedule makes it more resistant to change and more persistent, as well as being less work for the reinforcing agent.

If at any time you get a resurgence of undesirable behavior and you are sure that no one has been attending to it, you may be allowing too much time to pass between reinforcements. An unusual situation such as a persistent illness would also require closer management and richer schedules. During followup consult on such problems with other parents or staff, around sessions, during Project participation, or during group meetings.

The first time your child becomes ill, consult with the module coordinator to determine how the program should be adapted.

Second, if you stop and think about it, <u>you</u> had a very long intermittent reinforcement history for your old behavior, which probably made it very durable. We have been able to move very fast through intervention because we assumed that you would have considerable opportunity to consolidate and practice what you have learned. You may be asked to do this as a technician in oppositional child training or elsewhere in the Project or both. Your service will be determined by your interests, by personnel needs, and by what the staff feels is the best experience for you. In any event, you will continue to learn by teaching others, and also by applying the principles you have learned across a variety of behavior problems and training situations.

Related to our second point is the matter of "cabin fever" or "suburbiaitis." We have yet to research the question experimentally, but most of the mothers report that Project participation helps them beyond helping with generalization and consolidation. Just getting out of the house helps somewhat, but being able to give desperately needed service for which they are highly trained can add meaning

beyond mere escape. One of the ironies or paradoxes of our child-oriented society is that many mothers approach childrearing with no formal preparation and spend their children's preschool years in a purgatory of "waiting 'til the kids are in school." Through the Project, your children's preschool years can be a delight to you and a time of personally satisfying social contribution as well.

It is not unreasonable to hope that in part through your efforts your children may absorb your hard-won knowledge as part of their highschool curriculum and that should your grandchildren have physical disabilities, a coordinated service system will be available to provide effective help.

Third, you are going to have some additional troubles with your child. In part this may be because you encounter new situations. In part, it may be because all things are relative and there is always some respect in which he is "worst." If you have no other children, you also may have trouble arriving at an ability to assess behavior as "normal," especially after a year or more of worry and concern. Regardless of the reasons, you will have additional problems. The concept of "cure" has no place in the functional analysis of behavior when there are no physical problems. If the change in behavior was effected by manipulations of environmental consequences, as it was with your child, it makes no sense to expect the behavior to remain constant in the face of further environmental change. Indeed, given that change is the only constant we know, it should be expected and planned on. We should not think in terms of change vs no change, but in terms of programming for positive change vs not programming. Your training to date has been based on the assumption that once the emergency situation was dealt with, ample time would be taken to help you gain the ability to work out programs more and more on your own.

Therefore, generalization training will proceed not only across new situations, but in terms of the depth of your understanding. Ideally, all Project parents

should be able to analyze technically classic problems such as misbehavior while mother is on the telephone and independently work out and implement a corrective program.

Finally, there is the matter of your child's development. We have moved in fast at a particular period in your child's life and chosen our techniques accordingly. If you were to merely rote learn the techniques without understanding the underlying principles, we would guarantee either trouble or eventual frustration. You would probably return to culturally-determined practices of childrearing that have already failed you once. As your child develops, the particular programs you have learned will no longer apply. The empirical generalizations (principles of behavior) on which they are based, however, will apply, and can always be used to decide between programs.

Actually, if you think for a moment about the effects of schedules of reinforcement, childrearing may contain a built-in guarantee of inefficient or ineffective parent behavior unless the parent is trained. When the child behaves for a while in a certain way, the parent is reinforced, usually intermittently, for a certain pattern of response to child behavior. The parent's behavior tends to become more resistant to change as a result, but the child continues to develop. Non-scientific observations of the resulting discrepancies have been around for years. Remember the TV commercial, "Mother! I'd rather do it myself"? And the familiar jokes about the 75-year-old mother who fusses at the 55-year-old successful executive for not wearing his overshoes? Clearly, an intermittent reinforcement schedule has maintained behavior long after it is needed.

Those above are extreme examples. We see every week the more usual case in which the child has outgrown old activities. The parents, confirming the

law of least effort, are still under the effects of the old schedule of reinforcement. Then they report with alarm that the child is starting to misbehave. It usually turns out that the parents, not having redefined appropriate behavior in line with the child's development, are reinforcing it less. New developments in inappropriate behavior are attracting their (often frustrated) attention.

Fortunately, a psychologist named Wes Becker has done a good job of writing a child-management text. We think it is inadequate for children under four because it is written mostly for the parents of school age children. The title is Teaching Children. It costs $4.35. Buy it at the college bookstore or order it through a bookstore from the Englemann-Becker Corporation, Station A, Box 2157, Champaign, Illinois, 61820. We will loan you a copy if you cannot afford one now. Read first the section on "How to Reinforce," pp. 91-106, and put this section into effect at once in consultation with the technicians. Then, study the rest as you need to. (If you have older children, you need to.) You will then lack only two things: (a) information on growth and development norms, and (b) opportunity to talk about children with parents who are as sophisticated as you are. Although his advice on behavior ranges from commonsensical to silly psychoanalytic, Dr. Spock's Baby and Child Care is still good for the norms. The other RIP parents provide the opportunities for conversation.

At some point during Intervention II if your child is not going into the RIP preschool the liaison teacher or her assistant will arrange an appointment with you. They will want to talk to you about your plans regarding preschool experiences for your child, now or in the future. Liaison services have considerable information regarding preschools in various areas of Metro and they will provide you with relevant information or advice. After your six months consolidation, liaison services will be responsible for evaluation of your child and will be available to you for consultation.

For most of the children in oppositional training, there is little need to be apprehensive regarding their behavior in a preschool setting. Apparently some former oppositional children were models of good behavior away from home; most will not be difficult for a preschool teacher to manage. In most cases the liaison teacher will probably advise you to not inform your child's teachers of his former problems or his having been in the RIP Project. Unless the teacher is known to have understanding and tolerance, informing her might lead to her handling the child in such a way as to elicit problem behaviors as a function of her expectations. We know some teachers can handle knowledge of a child's former problems, and as a result of the knowledge be better equipped to shape the child's behavior positively. We have reason to believe that informing other teachers is detrimental to the child's progress. When in doubt, don't!

In any case, liaison services are prepared to intervene and to train teachers of former RIP children in behavior management techniques. This can be done without informing the teacher as to which child in her group was in the RIP Project. The fact that your child was in RIP will be treated as confidential as long as you so desire by all the staff.

In addition to behavior management and consultation, liaison services are prepared to help with educational programming at home and at school when this is desirable for a child.

Happy Childrearing!

Technicians

Give this section after the last reversal session. Inform the manager as session frequency is reduced. After a high level of cooperation is regained but before sessions become infrequent make sure that the mother can do everything

you can do and check her out by letting her do everything herself (except rate the session she is in). Use your good judgment as to when to train her to score, following the strategy of "all other things being equal, better sooner than later."

Manager

Keep a checklist that shows the mother's ability to perform each of the technicians' functions. Discuss best work assignment for her with module coordinator.

Module Coordinator

In staff conference tentatively plan the mother's work assignment for maximum mutual benefit, consolidation, and additional training. Explain tentative plan to her to be sure that she understands its purposes and perceives it as a challenging opportunity. When all are agreed, so inform Project Coordinator.